A Survey of Opinions About the Acquisition and Use of Medical Information in the Workers' Compensation Claims Adjudication Process

Chapter 4

Downloadable Version, Part 2 of 3

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For the State of Washington
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MedFx, LLC
Mill Valley, CA 94942
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B. Timing of Data Acquisition

Acquire Data as Quickly as Possible

There was universal agreement that data should be acquired as quickly as possible after it is generated. Proactive insurers and third-party administrators work with both large and small employers and physician organizations to ensure immediate notification of new incidents or health problems. They distribute claims kits and educate employers about the importance of immediate action to ensure that the worker's health concerns are addressed quickly. A common practice is to expect notification of the insurer within 24 hours of injury. They provide feedback to their clients including data on the proportion of claims reported within the desired intervals.

Starting the Data Acquisition Process

The acquisition of medical information about a work-related health concern starts with ensuring that those managing the case are notified of the health problem as soon as possible. This can be done using formal and informal telephone reporting, faxing of reports, or electronic means.

Completing Data Acquisition for Claims Management

After initial notification, the preferred practice is then to have a deadline for completion of "three-point contact" with the attending physician, the injured worker, and the employer. Among those who have standards for completion of three-point contact, the requirements range from 24 to 48 hours from the time of knowledge.

Regular Updates of Relevant Information

Adjusters or nurses managing the case need timely information during the case as well. Ideally, the attending physician submits visit, test or procedure records and

functional assessments immediately after the contact. When there are networks or contracts with employers or payers in place, there is usually a prior agreement between physicians or clinics and the payer to submit visit information immediately. If no prior agreement exists, the preferred practice currently is to require written updates every 15 days if the injured worker is off work, or every 30 days if he or she is at work but still receiving treatment.

Closing the Claim

At claim closure, it is a preferred practice to collect data quickly so that the process flow is timely, information is not lost, and the anxiety for the claimant about the ultimate outcome is reduced.

C. Who Collects Information

The Initial Collection of Information

The First Report of Injury usually contains the initial set of data received on a new claim. The most progressive organizations have centralized reporting into a Call Center, or to receive First Reports by electronic means. The Call Center may collect additional data, and some companies ask for supplemental data with the First Report.

In most cases, claims adjusters collect information after the first report is received. Whether they are able to collect it in a timely manner or in adequate detail depends on their caseload and level of experience. In organizations with a high caseload, information acquisition may be delayed or insufficient.

Collecting More Complex Medical Information

Some organizations devote considerable training resources to assisting adjusters in determining when a diagnosis or treatment plan is unclear, illogical, or deviates from guidelines. In these cases, a referral to a nurse for the collection of additional data is effective. It is for this reason that some participants feel that nurses should collect all telephonic medical information. Nurses with appropriate training and experience are generally skilled at interacting with both physicians and injured workers.

Medical directors or occupational medicine consultants are seen as the most effective people to obtain medical information, although they are usually reserved for complex cases or uncooperative interviewees because of the relative cost of their time. Physicians working with payers or employers may intervene quite effectively with local physicians, especially if they know the community.

Physicians are primarily used to acquire information about and to discuss controversial diagnoses or treatments.

D. Who Uses Medical Information

Multiple Users

While adjusters are the most common users of medical information for claims management, many others use the data as well. Nurses, physicians, psychologists, physical therapists, and vocational rehabilitation consultants may use medical data collected for the case to manage care or disability. Network managers may employ resource use or other data to monitor network and individual provider performance.

Bill auditors use medical records to validate bill coding and charges. Employers may use some data, primarily functional abilities, to manage individual and collective return-to-work programs. Attorneys, administrative law judges, and Appeals Boards use medical information to advocate and decide disputes.

Claims organizations increasingly see claims triage as a function that assures claims are routed to care managers with appropriate levels of medical and claims expertise. The historical method of assigning medical-only claims to junior claims adjusters and lost time claims to more senior employees is being augmented with more sophisticated methods. The more forward-looking organizations are testing or developing automated or computerized ways to feed medical and claims information obtained during the initial three point contact process into a decision support system and then assigning a claim to an appropriate team. In addition, these automated systems identify "red flags" in the available medical data or other information that indicates the need for more intensive or expert management.

Persons Who Acquire or Use Medical Information					
Q. 5	Insurers	State Funds	Third Party Administered / Self Administered	Regulators	International
Managed Care Organization	40%	20%	0%	0%	0%
RN	80%	20%	25%	0%	0%
Med Director	40%	20%	0%	0%	0%
Medical reviewers	40%	0%	25%	0%	0%
Chiropractors	20%	0%	0%	0%	0%
Case managers	20%	0%	50%	0%	0%
Attorneys	20%	40%	20%	43%	0%
IME examiners	20%	0%	0%	0%	0%
Employers	0%	20%	13%	0%	0%
Bill auditors	20%	0%	0%	0%	0%
Voc Rehab counselors	20%	20%	38%	0%	0%
Networks	20%	0%	0%	0%	0%
Patients	0%	20%	13%	0%	0%

E. Making Medical Expertise Available

Published Resources

A wide variety of medical expertise is available to claims adjusters. The expertise can be made available through printed materials, as written resources, and through personal consulting. Which ones are used for a given issue depends on the situation. Publications currently in use include the Physician's Desk Reference, FDA Bulletins, output from the AMA's Technology Assessment program, the National Library of Medicine on-line, and various clinical practice guidelines. These guidelines include those from the Center on Outcomes and Guidelines, the American College of Occupational and Environmental Medicine's guidelines, the *Medical Disability Advisor*, and one reference to the *Official Disability Guidelines*. Proprietary and state-mandated guidelines are also in use. The AMA's *Guide to the Evaluation of Permanent Impairment* and state impairment rating systems were not noted in our conversations, but have been observed in use on occasion.

Written Medical Opinions

Getting written opinions in the form of file reviews and answers to specific questions by in-house or contracted medical consultants is a recommended way for claims examiners to obtain medical guidance. Other sources of more formal written medical advice are independent medical examiners and physicians who provide peer review and second opinions.

Ad-hoc Availability of Medical Personnel

In-house medical and other specialty resources often provide timely, useful, and informal "on-the-spot" consultation. These include nurses, vocational rehabilitation consultants, occupational medicine consultants, and payer or corporate medical directors. The practices identified in this area related to

effective claims management are: (1) ensuring adequate availability of in-house resources so that advice is available on a timely turnaround basis, and (2) using in-house consultants to identify which claims need outside assistance and then to help formulate specific questions for that assistance.

	Medical Expertise Available to Adjusters			
Q. 6	Insurers	State Funds	Third Party Administered / Self Administered	Notes
Medical Director	60%	40%	13%	
NCM	20%	0%	50%	
Managed Care Organization physicians	20%	20%	0%	
Nurses	60%	40%	13%	
Inter/intranet FAQs etc	40%	0%	0%	
HQ Medical	60%	20%	0%	
SSO physicians	40%	0%	0%	
IME physicians	40%	0%	0%	
Call center	20%	0%	0%	
Books on line	20%	0%	0%	
Guidelines	60%	0%	0%	Believed to be underreported
National Library of Medicine	20%	0%	0%	Believed to be underreported
Medical textbooks	0%	0%	25%	Believed to be underreported
VR Counselors	20%	0%	25%	
Occ Med Physicians	0%	0%	25%	Believed to be underreported
Attorneys		20%		

F. Sequence and Forms of Data Acquisition

General Methods

The most timely and efficient means of acquiring medical data is via telephone, E-mail, or on-line methods, including the Internet. Most of our discussions dealt with the initial acquisition of data that constitutes the majority of data collection efforts for most claims. E-mail or on-line methods are desirable, but many providers and payers are not equipped to use them. Many participants feel that electronic communication will be the most efficient method when it is widely available. The most *common* means of acquiring first reports and other medical documentation is by fax or U.S. mail.

Security Concerns

There are concerns about the security of electronic data transmission and about retaining paper copies of the records for legal purposes. However, group health providers regularly file reports with regulators electronically and accept electronic billing and other data. Further, electronic signatures are now legal under Federal law.

Medical Data and Structured Forms

Many payers and states have experimented with the use of well-structured forms to obtain medical information. Forms are efficient, but many physicians see them as duplicative of office records and therefore resist them. Because it appears that physicians in general do not provide enough useful information on functional abilities, Texas and Kentucky among others have adopted forms that focus on function. The Washington State Medical Association has recently created a progress report with a similar intent.

	Sequence of Information Acquisition				
	from AP, Second Opinion, or IME				
Q.7	Insurers	State Funds	Third Party Administered / Self Administered	Regulators	Notes
Physician screening	20%	0%	0%	0%	Not mutually exclusive
Case by case decision	20%	20%	0%	0%	
Ask Attending Physician first	80%	40%	75%	50%	Not mutually exclusive
Voluntary second opinion	60%	20%	25%	14%	
Designated/tiebreaker exam	40%	20%	0%	29%	
IME as last resort	60%	60%	75%	29%	
QME or IME in disputed cases	40%	0%	0%	57%	May be underreported
Automatic triggers for IMEs	20%	20%	13%	14%	May be underreported
Ordered by judge	0%	0%	0%	100%	
Ordered by attorney	20%	0%	0%	43%	

	Form in Which Initial Medical Information Is Supplied				
Q. 8	Insurers	State Funds	Third Party Administered / Self Administered	Notes	
Forms	40%	80%	38%	Underreported- forms required	
Narrative Reports	60%	60%	63%	May be underreported	
Phone	20%	80%	63%	Underreported-should match TPC	
Fax	100%	60%	63%		
E-mail	80%	60%	50%	Low use, increasing	
Internet	40%	20%	13%	Low use, increasing	